**Fee-for-Service Pharmacy Consolidation Frequently Asked Questions**

**Q1:** How do I submit claims for a newborn who does not yet have a BadgerCare Plus member identification number?

**A1:** A newborn's fee-for-service member ID is generally in the Wisconsin Enrollment Verification System within three to five days of the child's birth. You can check for the newborn's own fee-for-service member ID using Automated Voice Response (AVR) system at (800) 947-3544 or (608) 221-4247.

If the newborn's number is not available for a specific date of service (DOS), verify the mother's eligibility using the AVR system. A newborn whose mother is eligible on the DOS is also eligible under the BadgerCare Plus continuously eligible newborn policy.

**Claims Submission**
If the newborn's member ID is on file, submit the claims through the real-time point of sale (POS) system. If not, the provider may hold the claim until the newborn's number is on file and submit the claim through POS. The provider may also submit the claim using the emergency supply policy. For more information on the emergency supply policy, refer to the February 2007 *Wisconsin Medicaid and BadgerCare Update* (2007-14), titled "Emergency Medication Dispensing." which can be found on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/updates/2007/2007-14.htm*. For more information on the newborn reporting policy, see the June 2003 *Update* (2003-29), titled "Wisconsin Medicaid will no longer reimburse claims submitted for newborns under the mother's identification number," which can be found on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/all_provider/archives.htm*.

**Q2:** Does grandfathering apply to brand medically necessary mental health drugs?

**A2:** Grandfathering applies only to non-preferred mental health drugs. For fee-for-service members taking a brand name mental health drug for which there is a generic, grandfathering does not apply.

**Q3**: Where do I send my pharmacy grievance or appeal?

**A3:** If your grievance or appeal has a DOS prior to February 1, 2008, it should be sent to your HMO. If your grievance or appeal has a DOS on or after February 1, 2008, send it to BadgerCare Plus fee-for-service, by contacting member services at (800) 362-3002.

**Q4:** How do I submit claims for a physician-administered drug?

**A4:** If providers are currently submitting claims for a physician-administered drug with a National Drug Code (NDC), submit the claim with an NDC to fee-for-service Standard Plan via the real-time POS system or on paper using the Noncompound Drug Claim form, HCF 13072, found on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid4/forms/index.htm*. If currently submitting claims for a

physician-administered drug with a *Current Procedural Terminology* (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code, continue submitting the claim with the procedure code to the HMO.

**Q5:** How do I submit claims for home infusion drugs and supplies?

**A5:** If you currently submit claims for home infusion drugs and supplies using HCPCS or CPT procedure codes, continue using procedure codes and submit the claims to the HMO. If you currently submit claims for home infusion drugs using an NDC and for supplies using procedure codes, submit the drug (NDC) claim to fee-for-service Standard Plan using the POS system or on paper and the supplies (HCPCS or CPT codes) to the HMO.

**Q6:** What are the helpline contacts for more information on the pharmacy consolidation?

**A6:** Provider Services — (800) 947-9627 or (608) 221-9883.
Hours: 8:30 a.m. – 4:30 p.m. Monday, Wednesday-Friday
9:30 a.m. – 4:30 p.m. Tuesday
9:00 a.m. – 4:00 p.m. Saturday-Sunday (February 2, 3, 9, 10, 2008, and April 5, 6, 12, 13, 2008, ONLY)

Member Services — (800) 362-3002 or (608) 221-5720
Hours: 7:30 a.m. – 5:00 p.m., Monday-Friday
9:00 a.m. – 4:00 p.m. Saturday-Sunday (February 2, 3, 9, 10, 2008, and April 5, 6, 12, 13, 2008, ONLY)

STAT-PA — (800) 947-1197 or (608) 221-2096
Hours: 8:00 a.m. - 11:45 p.m., Available via touch tone phone seven days a week.

STAT-PA Help Desk — (800) 947-1197, press "0" or (608) 221-2096, press "0"
Hours: 8:00 a.m. – 6:00 p.m., Monday-Friday

**Q7:** Where can I find additional BadgerCare Plus pharmacy consolidation information on the Web?

**A7:** Refer to the following Web sites for additional information about pharmacy consolidation:

- The Pharmacy Consolidation Project page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid4/pharmacy/consolidation/index.htm*
- The All Provider Handbook *at dhfs.wisconsin.gov/Medicaid2/handbooks/all-provider/index.htm*
- The Pharmacy page of the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/pharmacy/index.htm*

**Q8:** Will a child still be able to get Synagis treatment if he or she turns 2 years old after February 1, 2008?

**A8:** Yes, providers should submit claims for Synagis for a child who turns 2 years old during the Respiratory syncytial virus (RSV) season using the paper Noncompound Drug Claim form, found at the Medicaid Web site at *dhfs.wisconsin.gov/medicaid4/forms/index.htm*. The claim should be submitted with the Pharmacy Special Handling Request form, HCF 13074 which can be found on the Medicaid Web site at *dhfs.wisconsin.gov/medicaid/forms/index.htm*. The special handling claim form should include information on the medical necessity for continuing Synagis.

**Q9:** How do I obtain a prior authorization (PA) for a drug whose labeler does not have a Centers for Medicare and Medicaid Services signed manufacturer rebate agreement?

**A9**: Wisconsin Medicaid requires paper PA for certain drug categories produced by manufacturers who signed drug rebate agreements with the CMS in order to determine medical necessity. A list of these drug categories requiring PA can be found in the Covered Services and Reimbursement section of the Pharmacy handbook. *dhfs.wisconsin.gov/medicaid2/handbooks/pharmacy/pa/paframe.htm*

Request PA for covered rebated drug categories by submitting a paper Prior Authorization Request Form (PA/RF), HCF 11018 and a Prior Authorization/Drug Attachment (PA/DGA) for legend drugs. The prescription documentation must be valid on the grant date of the PA request. Refer to Appendices 8, 10, and 11 of the Prior Authorization section of the Pharmacy Handbook for a sample PA/RF and for PA/DGA forms for photocopying.

### Covered Non-Rebated Drugs That Require Paper Prior Authorization Requests

Certain drugs require paper PA because their manufacturer did not sign a rebate agreement with HCFA. To request PA for these drugs, providers must submit a paper PA/RF, a PA/DGA for legend drugs, and a statement of medical necessity *and* cost effectiveness for these specific brand drugs.

### Documentation of Medical Necessity and Cost Effectiveness

The statement of medical necessity required for PA requests for non-rebated drugs must include the prescriber's conclusion that the non-rebated drug is the only available and medically appropriate product for treating the recipient, and the details of the recipient's clinical experience which led to that conclusion. The documentation of the recipient's clinical experience may include:

- A copy of the recipient's medical record documenting the dates and clinical details of therapeutic failures and the specific companies and generic products involved.
- A copy of the documentation provided by the prescriber about the recipient's experience of therapeutic failure with a generic product of one or more manufacturers.

- A prescriber's documentation of the recipient's blood levels showing that the blood levels were substantially lower when using a generic drug than when using the brand name drug.
- A copy of the recipient's records showing that other drug products within the same therapeutic class of drugs have been ruled out because previous clinical trials with that recipient produced ineffective or unsafe results (e.g., allergic response).
- A prescriber's documentation showing how some unique characteristic (e.g., dosage form, pharmaceutical formulation, therapeutic indication) of the drug prescribed is essential to assure the recipient receives specific medically necessary and cost effective treatment.

The following sample prescriber statements are *not* sufficient by themselves as documentation of medical necessity and cost effectiveness:

- "The recipient becomes ill on the generic drug."
- "The recipient is convinced that only the brand name drug will work for him."
- "Only the brand name drug is effective."
- "The recipient insists that the generic drug is ineffective."
- "It is my professional opinion that this recipient requires the brand name drug for his condition. Generic versions are unacceptable in the patient's treatment as they provide no benefit to him."